

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

454 12/01/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2012
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NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF CHATTANOOGA	STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to assure exits and exit discharges were accessible.

The findings include:

Observation on October 16, 2012 between the times of 12:00 p.m. and 1:30 p.m. revealed the following.

1. Delayed egress doors by boiler room 1 leading out to smoking area and the back of east corridor did not work properly or open upon testing.
2. Exits from the back of the building did not have a sidewalk that lead to the public way.

These findings were verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on October 16, 2012.

K 054 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3

This STANDARD is not met as evidenced by:

K 038

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

K-038

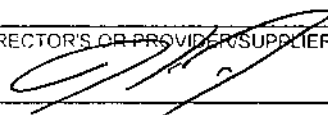
1. No residents suffered harm.
2. (1) Delayed egress door by boiler room door was repaired and operating properly on 10/16/2012. Delayed egress door located on the east corridor was repaired and was operating properly on 10/31/2012 (2) Sidewalk will be installed by 12/1/2012.
3. The facility's Maintenance Director will conduct QI monitoring to ensure that the facility's delayed egress doors are operating properly. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x monthly for 9 months. 100% of doors will be monitored.
4. The facility's Maintenance Director will report results of QI monitoring to the Quality Assurance/Performance Improvement (QA/PI) Committee monthly x 12 months for continued compliance and/or revision.

K 054

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

10-31-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 054	Continued From page 1 Based on record review and interview, the facility failed to assure smoke detectors were tested for sensitivity every two (2) years. The findings include: Record review and interview with the Maintenance Director on October 16, 2012 at 11:00 a.m. confirmed that the facility failed to test smoke detectors for sensitivity every two (2) years. This finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on October 16, 2012.	K 054			
K 067	NFPA 101 LIFE SAFETY CODE STANDARD SS-F Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure the fire dampers were maintained in accordance with NFPA 90A. The findings include: Record review and interview with the Maintenance Director on October 16, 2012 at 11:05 a.m. confirmed the facility failed to perform the required 4-year fire damper maintenance.	K 067	1. No residents suffered harm. 2. Smoke detectors were inspected and tested for sensitivity on 10/19/2012 by Simplex. 100% passed. 3. The facility's Maintenance Director will conduct QI monitoring to ensure that the facility's smoke detectors are tested for sensitivity every 2 years in accordance with the manufacturer's specifications. QI monitoring will be conducted monthly x 3 months, then quarterly x 9 months. 4. The facility's Maintenance Director will report results of QI monitoring to the Quality Assurance/Performance Improvement (QA/PI) Committee monthly x 12 months for continued compliance and/or revision. K-067 1. No residents suffered harm. 2. Fire dampers will be inspected and tested on by 12/1/2012. 3. The facility's Maintenance Director will conduct QI monitoring to ensure that the facility's fire dampers are maintained in accordance with NFPA 90A to include required 4 year fire damper maintenance. QI monitoring will		

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K 067	Continued From page 2 This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 16, 2012		K 067	be conducted monthly x 3 months, then quarterly x 9 months. 4. The facility's Maintenance Director will report results of QI monitoring to the Quality Assurance/Performance Improvement (QA/PI) Committee monthly x 12 months for continued compliance and/or revision.	

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